**A discussion is presented of the concept of advocacy and its implementation in various ways in community mental health programs. The implications, however, extend to the entire area of personal health services.**

# Advocacy in Community Mental Health Programs

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Advocacy as defined by Webster is the act of pleading the cause of another person. It is a term used more often in legal than in mental health matters.

Advocacy was highlighted in the report of the Joint Commission on the Mental Health of Children, "Crisis in Child Mental Health: Challenge for the 1970s."[1] The Commission recommended that a child advocacy system be established by forming councils at federal, state, and local levels which would have broad community representation. Each council would be responsible to see that services were made available for children in need but not to provide direct care. The councils would assess needs, plan how to meet them, and assure their accomplishment by obtaining facilities, funds, and manpower. The councils would thus serve as advocate bodies.

The concept of advocacy in human services is not new. Neighbors and families have been helping each other from time immemorial. It has been characteristic of western society that when individuals or families could not take care of common needs through their own resources, they moved through governmental channels to do so by establishing and supporting public institutions and facilities. Among these institutions were schools, hospitals, libraries, common water supply and sewage disposal resources, roads and parks. Often private philanthropy preceded governmental action in meeting human needs and provided a demonstration to spur public action. Private philanthropy supported free hospital care for the indigent, settlement houses in the slums, clean milk for babies in the ghetto, homes for the aged. Communities were smaller in times gone by and these facilities were usually located in the midst of the people who needed their help. These were visible institutions to which people could turn.

As our population increased, helping institutions grew larger and in the process became more impersonal and bureaucratic. Eventually, the maintaining of the institutional system or bureaucracy sometimes took priority over the goals and original purposes of the institution. Also, each community institution which had been established to answer a particular need elaborated a separate system with its own methods, procedures and traditions. After many years, this process has resulted in a variety of helping services such as schools, welfare, and health each of which operates independently and with its own rules, regulations, and requirements. Each system is an isolated entity often with little relationship to other systems.

The Joint Commission on the Mental Health of Children found that specialized services exist in many communities as a potential aid to families but the services "have become so specialized, frequently so expensive, so poorly coordinated, and so centered on individuals . . . that very few parents have resources that are needed to mobilize these services for the well-being of each family member or for the family as a unit."[2]

As this country emerged from the great depression of the thirties and the travail of war in the forties, social philosophies began to undergo reappraisal. The complexity of human resource agencies each with its own system began to be apparent. A shortage of human service manpower also became evident. During this same period disadvantaged minority groups began to press for inclusion in the mainstream of American life.

One of the results of the social philosophical reappraisal was the passage of the Community Mental Center Act by the Congress in 1963. This Act established a new organizational form and system to provide comprehensive locally based mental health services accessible and available to all people. Perhaps it was easier to make change in the mental health field which had long been an isolated system particularly for those who could not afford to pay for care. From the beginning, the new program emphasized building networks of human services. One center now is governed by a corporation composed of 38 community agencies and community representatives and another by a corporation of consumers and 16 provider agencies.

Traditionally, mental health care has been provided by professionals in psychiatry, psychology, social work, and nursing. Public mental hospitals have always employed large numbers of aides who functioned in auxiliary nursing capacities. However, when mental health services moved into community settings, it became evident that a new kind of worker was needed. Often patients arrived at the mental health center with problems that were not clearly labeled medical or mental health. Many of the problems were social but of a nature to produce severe anxiety and to disrupt behavior. Patients and clients burdened with problems of indigency and minority backgrounds needed help in dealing with reality based problems: crises of poor housing and impending eviction; brushes with the police and courts; children having problems in school; lack of money to feed and clothe a family. Many of the problems led to involvement of the center staff with other agencies and institutions. Communication and

channels of referrals between the various systems became essential. Experience showed that staff other than mental health professionals could be prepared to help clients and patients deal with social problems.

It also became evident that minority groups and the poor have life styles which are different from middle-class professionals who serve them. Local residents were hired to promote communication. Soon formal training programs were established for mental health workers. The Lincoln Hospital Mental Health Center in New York was one of the earliest centers to utilize the services of mental health workers. Local residents were solicited by newspaper advertising and word of mouth. A selection committee picked the candidates who seemed best qualified and then on-the-job training was provided with continuing supervision in a structured setting. Many mental health centers have followed this same pathway. Mental health workers now carry out a variety of duties. They serve as receptionists, take histories, make home visits, make interagency referrals, escort clients to other agencies and act as true advocates and interceders for clients who are unable to find their way through the maze of community agencies or cope with an emergency or a pattern of life.

As the mental health worker movement grew, the career ladder was created to allow upward mobility to those who had the motivation and the capacity to move upwards. Junior colleges began to formulate courses for preparing mental health workers. As of September 1970, at least 56 programs are known at the Associate of Arts level for the training of mental health workers. A smaller number of courses are available at the baccalaureate level and a few related programs exist at the Master's level.

There is considerable literature about mental health workers.[3,4,5,6] They are given various titles such as indigenous worker, incentive specialist, enabler, expediter, paraprofessional, and new professional. They usually fall into two categories, those who perform a therapeutic role and the advocate or ombudsman role. In the therapeutic role the worker is trained to do counseling and to enter into psychotherapeutic relationships. Counselors are used in alcohol and drug programs; college students provide companionship and recreation to mental patients. More than ten years ago, Dr. Margaret Rioch demonstrated a training program at NIMH which prepared mature women to serve as counselors in social and psychiatric agencies.[7] An increasing number of programs are now utilizing mental health workers as advocates to intercede with community agency and institutional systems on behalf of clients. Rieff and Reissman in their monograph on the indigenous non-professional say that the value of the worker relates to problems of fragmented health and welfare services in most communities and the reduced managerial competence of the ordinary public mental health patient.[8] The worker serves as a link between client and community resources; he establishes contact with these resources; he hears complaints from his clients and investigates them; he provides information to agency professionals about available resources and facilitates disposition; he interprets his role to the agency and to the public.

Mental health workers have been used in many creative ways. At a mental health center located in the inner city of Philadelphia, a program is underway which involves the center, a local self-help group of young people known as the Young Great Society and schools in the catchment area. The goal is to help schoolchildren develop their capacities and talents and help community psychiatrists assist the schools. Young people in their late teens and early twenties are selected and trained by the Young Great Society and then assigned to classrooms of several participating junior high schools. The incentive specialist, as he is called, motivates and assists students in the classroom, counsels, tutors, educates about drugs, helps with problem-solving, expands the child's cultural boundaries, and seeks constructive ways to modify disruptive behavior. He makes monthly home visits, works with parents and caretakers to promote family investment. He helps school faculty understand the ghetto and its residents. He serves as a bridge between students, community agencies and acts as a referral agent and advocate. An academically and socially adjusted senior high school student from the same catchment area assists the specialist in student activities.

There is another side to the advocacy role. Reissman points out that people who give help are profiting from their roles.[9] He cites as examples those affiliated with self-help groups such as Synanon, Recovery, Inc., and Alcoholics Anonymous. Reissman proposes turning the recipients of help into dispensers of help and in so doing they develop leadership abilities. He says, "Conscious planning directed toward the structuring of the group for the widest possible distribution of the helper role may be a decisive therapeutic intervention, a significant leadership training principle, and an important teaching device."

The role of the advocate, helper, or paraprofessional has become rapidly and widely accepted in a broad spectrum of health and mental health settings. An article in a recent Journal of the American Medical Association says that health care has been too narrowly defined.[10] Non-physician members of the hospital family care group must deal with socioeconomic problems that arise in the family unit and the family health worker is the backbone of the operation. "Recruited from the community and trained at the center she is an immediate and daily contact with families assigned to her care. She acts as the professional outreach of the entire family care group visiting the home, school or social agency to assist families in solving their problems. In addition she cooperates with the social worker in alerting all members of the family care group to non-medical problems as they develop. Thus, she provides the group with an awareness that enables the physician to provide health care in the context of the family's total environment."

Dr. Sol Levine, Chairman of the Department of Behavioral Science at the Johns Hopkins School of Hygiene and Public Health, sees a role for allied health personnel in overcoming the barriers of the formalistic setting of a hospital and clinic.[11] He points out that most patients from the disadvantaged segment do not complete medical referrals. "Allied professionals could take these people to the proper place and encourage them to complete the referral." He says that new careerists with high school educations

who serve as aides to professionals extend the health system in a creative way and allow new jobs to be developed. Johns Hopkins has created the position of "life career manager" in which new careerists help mentally retarded children manage daily living. Dr. Robert Gibson, Medical Director of the Shepard-Enoch Pratt Hospital, in a recent speech points to new mental health careers as part of the solution to the manpower problem.[12] He says, "by offering direct assistance with reality problems, serving as role models and providing corrective experiences (they) may help many people who may not be reached by more traditional methods."

Dr. Arnold Mandel,[13] Chairman of the Department of Psychiatry, University of California at San Diego, writes, "The intrapersonally effective and helpful person has been found to come from many kinds of educational background and may be available in far larger numbers than psychiatrists and at much reduced rates . . . the psychiatrist as a broadly trained doctor might be able to organize and consult with such indigenous talent and weld together mental health delivery systems."

Hard data is not available to show that the mental health worker as an advocate is more successful than other groups. There is evidence that they are providing a great deal of service in helping clients solve problems. They are also helping their clients to become more competent people in managing their own lives and learning how to maneuver in the system in which they live. The goal is to help the individual who comes for help to take care of his own needs. There is also the strong possibility that as increasing numbers of people learn how the systems work, they will make efforts individually and in a concerted fashion to change the institutions to be more responsive to their needs.

It adds up to an educational process. Indigenous people are trained to provide help to their peers and neighbors. As the peers and neighbors become more conversant with the system and adept at problem-solving they will, in turn, become helpers. As awareness and knowledge grows in an increasing number of people, there will be pressures to bring about institutional change to be more responsive to those the system serves. "Attempts to educate the population to a limited degree on how to use health services have been humbling . . . while we make the way easier, we must identify key people whom others will follow and train them how to use the system properly."[14]

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